

HISTORICAL OVERVIEW OF THE CHOLERA OUTBREAK IN ZIMBABWE (2008-2009)¹

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Abstract

This article provides a historical overview of the 2008-2009 cholera pandemic in Zimbabwe. Its main hypothesis is that this outbreak revealed serious health status implications that were not unconnected with a malfunctioning economic and governmental order. The epidemic, of pandemic proportions, has deep-seated historical roots in the country's economic meltdown. Furthermore, it is linked to the exclusion of local municipal authority from its traditional water-governance role. The article discusses the epidemic and evaluates the country's disaster preparedness, bearing in mind that this outbreak was by no means the first in Zimbabwe. At the policy level, sanitary reforms were vital in view of the lukewarm government response to what was a very real national state of emergency. Drawing on an array of United Nations (UN), Red Cross, Ministry of Health and media perspectives on the cholera outbreak in Zimbabwe, the article focuses on the debate about the erosion of what was a good health system in Africa and the degeneration of a previously sound water, health and sanitation infrastructure.

1. INTRODUCTION

In examining the 2008-2009 cholera pandemic in Zimbabwe, this article's main contention is that the outbreak revealed enormous health problems hardly divorced from a government in a state of economic flux. The water and sanitation-related disease, sometimes known as Asiatic or epidemic cholera, is an infectious and contagious gastroenteritis caused by cholera toxin or enterotoxin-producing strains of the bacterium *vibrio cholerae*.³ Transmission to humans occurs by eating or drinking food or water contaminated with cholera vibrios. The mechanism by which cholera causes death and disease is by fast multiplying, causing the body to lose fluid rapidly, so that body fluids are unable to maintain the basic circulation.⁴ The

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3 *Vibrio cholerae*, the causative agent, belongs to a group of organisms whose natural habitats are the aquatic ecosystems. The strains that cause cholera epidemics evolved from non-pathogenic progenitor strains by acquisition of virulence genes, and *V. cholerae* represents a paradigm for this evolutionary process. For detail on this see SM Faruque, "Introduction", in SM Faruque and G Balakrish Nair, *Vibrio cholerae Genomics and molecular biology* (Dhaka: Caister Academic Press, 2008). (Internet accessed 7 April 2009.)

4 Timothy Stamps, "The truth about cholera, Part 4", "Health Talk", *Saturday Herald*, 28 March 2009, p. 10.

epidemic, which resulted in the launching of the biggest cholera-related appeal for humanitarian aid in Africa, was precipitated by economic underperformance and the take over by the state of the urban water supply system previously administered by the local town councils. For several years, the inadequacies of an underresourced state agency, the Zimbabwe National Water Authority (ZINWA),⁵ which presided over all aquatic matters in the country before the emergence of the Government of National Unity (GNU), had failed to deliver clean water and appropriate sanitary facilities to residents. The critical outcome was a cholera-outbreak of epidemic proportions. The ineptitude of the water authority, which was suffering from serious funding, personnel and equipment bottlenecks, generated public discontent with the substandard water delivery provision. Matters came to a head with the outbreak of cholera and other diarrhoeal diseases in the spring of 2008.

The article further examines whether the health delivery system in Zimbabwe was so hopeless as to lead to an outbreak of cholera – a disease that has recurred every other year since the economy went into a backslide in the late 1990s. The problem was compounded by the seemingly ceaseless political bickering between the main political rivals (now “partners”), the then ruling Zimbabwe African National Union-Patriotic Front (ZANU-PF) party led by President Robert Mugabe on the one hand, and the Movement for Democratic Change (MDC) formations led by Premier Morgan Tsvangirai and his Deputy, Arthur Mutambara, on the other. Under the new and inclusive political dispensation facilitated by SADC,⁶ it can be observed that the three were uneasy bedfellows given their different ideological backgrounds. This did not augur well for the full containment of the pandemic and the restoration of normality

5 ZINWA was established as the state moved in to control both rural and urban water supply in Zimbabwe in an attempt to curb the rising popularity of the MDC which controlled most of the urban council positions, particularly after the 2000 elections. It started with several amendments to the Water Act (1976), which was replaced by the Water Act of 1998. In May 2005 a government decision effectively led to the transfer of the governance of water resources and sanitation from the Harare Metropolitan area to ZINWA – a decision that exacerbated the situation as water-borne diseases broke out regularly in the capital. See Government of Zimbabwe, *Towards integrated water resources management* (Harare: Ministry of Rural Resources and Water Development, Government Printer, undated); Government of Zimbabwe, *Zimbabwe National Water Authority Act* (Harare: Government Printer, 1998), chapters 20, 24 and 25. See also H Makurira and M Mugumo, “Water sector reforms in Zimbabwe: The importance of policy and institutional coordination on implementation”, Harare: Proceedings of the African Regional Workshop on Watershed Management, undated, chapter 14 (Internet accessed 4 May 2009); AfDevInfo, “Zimbabwe National Water Authority”, Department of Water Resources, undated (Internet accessed 4 May 2009); Anon, “New ZINWA Board of Directors appointed”, ZBC News, 9 April 2009 (Internet accessed 4 May 2009) and M Musemwa, “The politics of water in post-colonial Zimbabwe, 1980-2007”, Seminar paper for presentation at the African Studies Centre, University of Leiden, Netherlands, 19 June 2008, pp. 1-32.

6 The agreement was initially signed in September 2008, but it did not come into effect until February 2009.

to service delivery in the water sector. For Zimbabwe's citizens, cholera became a serious governance issue in the country as the cholera outbreak and all its baneful effects were largely seen as a reflection of a faulty and shattered health infrastructure. The poor people in urban areas who fall within ZINWA's area of jurisdiction in conjunction with their rural counterparts invariably bore the brunt of this state of affairs. Indeed, the precarious position of poor households who were more vulnerable to cholera than their resource-rich counterparts was clear. The less-to-do could not access clean water in circumstances of economic collapse. It is disconcerting to note that at the height of Zimbabwe's economic, political and humanitarian crisis, the dilemma of the poor was exacerbated by the non-availability of salt and sugar to make the "very simple household remedy [solution] consisting of 8 heaped teaspoonfuls of sugar, 1 flat (level) teaspoon of salt in 1 litre of clean water" which cholera victims urgently needed to replace body fluids and electrolytes.⁷

The first cases were recorded in Harare's Budiriro followed by Chitungwiza's Unit "O" high density suburbs in August 2008. Since its outbreak, the pandemic spread slowly throughout the country until November/December when it escalated with the onset of the summer rain season. The capital, Harare, was the epicentre of the disease. However, between August and November 2008 the government was in a state of denial regarding the cholera reality. Instead the state tried to downplay the impact of cholera on the country. Government only declared cholera a national emergency on Wednesday 3 December 2008. By December the government was at pains to admit to the nation that its previously strong capacity to deal with such pandemics was gradually but surely whittled away by its dwindling fortunes in a very difficult macro-economic environment.

It is true that the disease had never before struck Zimbabwe with the ferocity that it did in 2008-2009. In fact, epidemiological reports indicate that prior to this onslaught cholera appeared to be a thing of the past because earlier outbreaks from the 1970s onwards had been effectively contained. However, a derelict water infrastructure which was not properly maintained over several decades of ZANU-PF misrule, made it impossible to prevent the 2008-2009 outbreak. The cholera outbreak, its fatal persistence despite of it being a treatable and preventable disease, starkly revealed the diminishing capacity of Zimbabwe's public health facilities to deal with a situation that exceeded all "worst scenario" projections. Following the belated pronouncement of an emergency, international humanitarian agencies and non-governmental organisations (NGOs), in collaboration with the government, played an increasingly visible role in health care provision in Zimbabwe. The reasons for collaboration vary, but the chronic and depleted state of government health services, due to the economic turmoil, was clearly an important factor.

7 Stamps, p. 10.

At the policy level, sanitary and health sector reforms are vital to prevent future outbreaks of cholera. Such reforms could not however be implemented immediately due to a critical lack of funds. Even the Short-Term Emergency Recovery Programme (STERP), adopted between 3 and 5 April 2009 by the inclusive government created under the SADC-brokered Global Political Agreement (GPA) to review several macro-economic related issues, did not primarily focus on water and cholera prevention. STERP merely tried to address the challenges of underfunding of Zimbabwe's cholera operations. Overall in order to deal with the pandemic the state committed itself to improving the quality of water delivered to the people. Indeed, fighting the epidemic was one of the most urgent tasks of the embryonic coalition government. Ostensibly, cholera history in Zimbabwe can best be understood within the context of what transpired both before and after the establishment of the unity administration.

On the basis of the foregoing, this article aims to present an overview of the cholera epidemic in Zimbabwe from August 2008 to October 2009, paying particular attention to causative factors, effects, and how this catastrophe raised levels of awareness about the disease among ordinary citizens, ministry of health officials and other stakeholders. Donors especially played a key role. Zimbabwe witnessed a flood of donor assistance directed at alleviating the plight of ordinary people and clamping down on cholera by resuscitating the collapsed health sector. This article therefore examines what had led to serious water and health sector collapse. Indeed, a plethora of factors, including ill-preparedness on the part of the Zimbabwe government to deal with an emergency situation combined to lead to the outbreak of arguably the deadliest water-borne disease in recent history.⁸

2. CHOLERA: THE STATISTICS AND THE SOCIO-ECONOMIC AND POLITICAL ENVIRONMENT

2.1 Cholera: a scary time bomb

Cholera, which claimed thousands of lives, infected tens of thousands of people and left millions of impoverished, hunger-stricken or half-starved Zimbabweans living in fear of their own drinking water, was one of the most visible signs of Zimbabwe's

8 For comparative and specific literature on cholera in Zimbabwe and internationally, see Barua and William B Greenough III (eds), *Cholera (Current topics in infectious disease)* (Springer, 1992) (Internet accessed 5 March 2009); M Bradley *et al.*, "Epidemiological features of epidemic cholera (El Tor) in Zimbabwe," *Transactions of the Royal Society of Tropical Medicine and Hygiene* 90(4), July-August, 1996, pp. 378-382; C Pazzani *et al.*, "Molecular epidemiology and origin of cholera reemergence in Italy and Albania in the 1990s", *Research in microbiology* 157(6), July-August, 2006, pp. 508-512 (Internet accessed 6 April 2009); R Pollitzer, *Cholera* (Geneva, WHO, 1959); Charles E Rosenberg, "The cholera years" and J Stephenson, "Cholera crisis in Zimbabwe," *The Journal of the American Medical Association* 301(11), March, 2009:1118.

collapse.⁹ For a Harare man only identified as Tongesai, “(t)he cholera is coming from the water which is contaminated. It is not the boreholes that are bringing in the contaminated water but the water from the city. That water is now getting to the people without being treated and that is how people get cholera. It is tantamount to drinking raw sewage.”¹⁰

In some places the water supply was cut off completely, forcing people to use stagnant ponds and open streams for drinking and cooking.¹¹ A local councillor for Tafara, another of Harare’s high-density suburbs, admitted: “With the problems of cholera, we are sitting on a time bomb.”¹² In a letter addressed to the editor of *The Herald*, Stanley Penyai Matute, one of the business persons operating from Tichagarika Shopping Centre in Glen View’s Area 8 in Harare, expressed similar sentiments, citing the non-availability of running water in public toilet facilities as a health hazard. In particular, he highlighted the dangers the public toilet at the centre was posing to “clients and the general public”.¹³ Matute claimed that the toilet had not been functioning properly for many years and members of the public, including patrons of the bottle stores, dotted around the place resorted to relieving themselves outside the toilet. This was a health threat to a number of butcheries and food outlets at the shopping centre which catered for many people who resided in Budiriro I, where a significant number of cases of cholera (more than 8 000) had been recorded in the period after August 2008. Matute urged the responsible authorities of Glen View to “do something about this toilet because the current state of affairs will undo all the hard work that has been put [by various local and international organisations] into trying to eradicate the prevalence of cholera”.¹⁴ Such sanitary problems partly explain why cholera cases continued to escalate in Zimbabwe.

The untenable nature of the situation was illustrated by one of the most active groups in the cholera field in Zimbabwe, *Médecins Sans Frontières* (MSF), also known as Doctors Without Borders.¹⁵ By February 2009 the group had handled

9 C McGreal and J Gilchrist, “Mugabe splashes out on birthday bash as cholera spirals out of control: Guardian film exposes horrors of man-made epidemic claiming thousands of lives”, *The Guardian*, 26 February 2009 (Internet accessed 12 March 2009.)

10 Anon., “Zimbabwe cholera: A plague of Robert Mugabe’s own making – Telegraph”, *Indigenist Intelligence Review*, 5 December 2008 (Internet accessed 6 January 2009.)

11 Most Zimbabweans could not vow not to drink from contaminated riverine sources as they did not have an alternative as Musa of KwaZulu-Natal in South Africa. For detail see L Torr, “Musa will not drink water from that stream again: Water and health” *The Water Wheel* 4(1), 2005:3.

12 McGreal and Gilchrist, “Mugabe splashes out on birthday bash as cholera spirals out of control”.

13 SP Matute, Letter to the editor, “Cholera time bomb in Glen View”, *The Herald*, Opinion and Analysis, 2 April 2009 (Internet accessed 2 April 2009.)

14 *Ibid.*

15 Doctors Without Borders/Médecins Sans Frontières (MSF), is an international independent medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, natural and man-made disasters, and exclusion from health care. It is working in more than 60 countries to assist people whose survival is threatened by violence, neglect, or

about 45 000 cases. MSF, together with other NGOs such as the Red Cross,¹⁶ played a key role in treating patients across the country at a time when many health facilities were not fully functional.¹⁷ It warned that the spread of the epidemic showed no sign of slowing, and that new cholera patients were being registered at an alarming rate of one a minute.¹⁸ For the NGO, “lack of access to clean water, burst and blocked sewage systems and uncollected refuse overflowing in the streets”, were clear indications of the “breakdown in infrastructure resulting from Zimbabwe’s political and economic meltdown”.¹⁹ Under these conditions, cholera led to numerous deaths despite speculation in the last week of February 2009 by a top WHO official, Daniel Acuna, that a massive effort by aid agencies might bring the epidemic “to a reasonable pattern of control” within three weeks. This was rather misplaced optimism as the public health system was by that time malperforming due to a gross lack of funding. Major hospitals in Harare and Bulawayo closed for months because health workers were not paid. The head of MSF in Zimbabwe, Manuel López, was concerned:

“There has been a devastating implosion of Zimbabwe’s once-lauded health system, which doesn’t just affect cholera patients. We [the MSF] know that public hospitals are turning people away, health centres are running out of supplies and equipment, there is an acute lack of medical staff, patients can’t afford to travel to pick up their HIV medication or to receive treatment and many of our own clinics are overflowing [with cholera-cum HIV patients]. From what we see each day it couldn’t be clearer – this is a massive medical emergency, spiralling out of control.”²⁰

Thus, in a distorted economy, factors such as hunger and undernourishment also contributed to the climbing death toll in one of the most serious outbreaks of the disease in Africa in recent times. It is less startling that food scarcity and malnutrition were widespread in a country where about seven million people – two-thirds of Zimbabwe’s population – were on food aid. Even those receiving maize and bean rations rarely got enough to eat. Many people were reduced to one meal or less a day which left people with weakened immune systems and highly susceptible

catastrophe. For this definition see MSF Special Report, “Better tests needed for TB”, undated (Internet accessed 7 April 2009.)

- 16 There is a clear distinction between the mandate of the International Federation of Red Cross and Red Crescent Societies (IFRC) and that of National Red Cross Societies. National societies are autonomous entities and the IFRC does not interfere in their affairs. See interview with E Okwanga, IFRC Deputy Head of Southern African zone, Sandton, 20 March 2009; interview with F Abdulkadir, IFRC Disaster Management Co-ordinator, Southern African zone, Sandton, 20 March 2009; interview with J Fleming, IFRC Health and Care Co-ordinator, Southern African zone, Sandton, 20 March 2009.
- 17 WHO, Epidemic and Pandemic Alert and Response (EPR), “Cholera in Zimbabwe, Update 3”, undated (Internet accessed 2 April 2009.)
- 18 MSF cited by Mcgreal and Gilchrist, “Mugabe splashes out”.
- 19 Mcgreal and Gilchrist, “Mugabe splashes out”.
- 20 *Ibid.* See also P Rusere, “Zimbabwe’s HIV/AIDS population obscured, decimated by cholera epidemic”, *The Zimbabwe Situation News Website*, 2 March 2009 (Internet accessed 13 March 2009.)

to diseases. According to Mcgreal and Gilchrist: “While around 20 people die daily from [cholera], hundreds die from Aids.”²¹ Funds to deal with a devastating combination of cholera and HIV/AIDS were not available and potential injectors of funds were scared away by endemic levels of corruption and lack of accountability.

2.2 Responses to an increase in cholera victims

Since the outbreak of cholera, the World Health Organisation (WHO) and its Global Outbreak Alert and Response Network (GOARN) partners deployed a sizeable team working in and out of the national Cholera Command and Control Centre (“C4”) in Harare.²² GOARN partners working with the Ministry of Health of the government of Zimbabwe and WHO, included the International Centre for Diarrhoeal Disease Research, Bangladesh; Burnet Institute in Australia; the London School of Hygiene and Tropical Medicine and Health Protection Agency in the United Kingdom (UK); United States (US) Centers for Disease Control and Prevention; and the National Board of Health and Welfare, Sweden.²³ The objective of the cholera control measures was, among other things, to extend the operations of the C4 to regional and district levels. According to the WHO’s regular updates, by the middle of February 2009, no less than 79 613 suspected cases of cholera were reported by the Ministry of Health and Child Welfare of Zimbabwe since the epidemic had broken out in August 2008. WHO health experts estimated late in 2008 that the worst-case figure could reach 60 000 – a level that was surpassed by January/February 2009.²⁴ Early in February the C4, comprising officials from the WHO, the Zimbabwe Health Ministry and aid agencies involved in combating the epidemic, forecast up to 92 000 infections.²⁵ However, with numbers ever increasing, medical experts in Harare, who fell under the Zimbabwean Association of Doctors for Human Rights (ZADHR), forecasted that a worst-case scenario in Zimbabwe’s rampaging cholera epidemic could see earlier predictions doubled to 123 000 cases and that this trend would continue beyond May 2009.²⁶ According to the ZADHR, the continuing speedy increase in cases and the poor state of the health, water and sanitation systems meant “the worst-case scenario of [over] 122 945 seem[ed] likely to occur if drastic improvements ... [were] not made immediately”.²⁷ These were not unfounded projections given the rapid and overwhelming pace at which cases and fatalities were being recorded.

21 Mcgreal and Gilchrist, “Mugabe splashes out”.

22 WHO, EPR, “Cholera in Zimbabwe, Update 3”.

23 *Ibid.*

24 Sapa-dpa, “Zimbabwe cholera cases could double – doctors”, *The Zimbabwe Situation News Website*, 3 March 2009 (Internet accessed 13 March 2009.)

25 *Ibid.*

26 *Ibid.*

27 *Ibid.*

In retrospect, it can be pointed out that up to December 2008, denialism characterised the response of the government of Zimbabwe to the cholera pandemic. The government claimed to have contained the disease. However, the announcement that the Zimbabwe government had “stopped” the cholera outbreak came hours after South Africa had declared the Zimbabwean border a “disaster area” on 11 December 2008. Whilst the Zimbabwean government was claiming that it had halted the cholera outbreak, WHO reports, on the contrary, indicated that the crisis had worsened.²⁸ Deaths from cholera in the capital, Harare, steadily increased throughout November and December 2008, and caused international alarm. In Budiriro alone, as of 28 February, 196 cholera deaths and 8 154 cases – nearly one-tenth of all cholera cases in Zimbabwe – had been reported. The highest number of deaths at a specific site by February, according to the WHO, was at the Beatrice Road Infectious Diseases Hospital, a government facility near the sprawling Harare high-density suburb of Mbare, where more than 265 people had died and over 5 135 cases had been reported.²⁹ On 13 December 2008, this culminated in the IFRC launching the Zimbabwe cholera appeal, as the aid agency also warned that the disease could run out of control.³⁰ Initially 300 000 Swiss francs were donated to Zimbabwe by the Geneva-based Disaster Relief Emergency Fund (DREF) to kick-start control of the disease.³¹ During the month of December 2008, the IFRC scaled up its activities in Zimbabwe because outbreaks were on the increase. This culminated in its launching of an appeal for US\$9,2 million on 23 December 2008.³² This was the biggest IFRC operation in Southern Africa and possibly one of the biggest cholera operations in the history of the Red Cross in Africa because it involved seven emergency operations, that is, the cooperation of all the seven IFRC zones worldwide.³³ Attempts to cover up the real scale of the outbreak delayed the arrival of international aid. The UN, IFRC and similar organisations do not intervene before being invited. They only mobilise resources to deal with disaster management when national governments and national societies³⁴ which stand as autonomous entities can no longer cope.³⁵

Cholera had earlier struck the southern Zimbabwean border town of Beitbridge in November 2008 and the government of South Africa initially blamed the outbreak

28 Mcgreal and Gilchrist, “Mugabe splashes out”.

29 IRIN, “30 strains of cholera”.

30 Mcgreal and Gilchrist, “Mugabe splashes out”.

31 Interview Abdulkadir.

32 IFRC, “Zimbabwe: cholera, emergency appeal”, IFRC, 23 December 2008, p. 1.

33 *Ibid.* See also interview with Okwanga; interview with Fleming.

34 National Red Cross Societies, for example, are in a privileged position because they are auxiliaries to their own ministries of health and are thus recognised by government. See interview with Okwanga.

35 Interview with Abdulkadir.

on Zimbabwe as many of the town's residents frantically sought medical care across the border in Musina.³⁶ In that month, sources in Beitbridge revealed that the outbreak had claimed about 50 lives, and that 500 people had been admitted to the Beitbridge Hospital with cholera symptoms.³⁷ According to the WHO, in the period before donors were called in to assist, the mounting death toll from the devastating cholera epidemic had reached almost 3 800 with more than 80 000 people infected between August 2008 and February 2009.³⁸ As the fight against cholera was stepped up and increasingly took on an international dimension, a specialist team dispatched to Zimbabwe under the auspices of the WHO discovered several cholera strains in a country blighted by the waterborne disease.³⁹ During the investigations in January 2009 by the ICDDR at sites across the country, from Harare to the second city of Bulawayo in the southwest, to Mutare in the east and in other rural locations, "a total of 30 [cholera] strains were isolated", indicating how much the population was at risk.⁴⁰ From the beginning of the outbreak in August 2008 until 1 March 2009, cholera had claimed the lives of 3 939 people, infected 85 300, and was reported in all the country's ten provinces (including Mashonaland Central which had been unaffected until November 2008) and 55 of its 62 districts. (See the map of cholera outbreak in Zimbabwe.) This prompted the ZADHR to admit that the epidemic had passed Africa's worst, which was Angola in 2007, when over 82 000 people were infected with the highly infectious waterborne disease and 3 204 had died. Of the reported 84 027 cases in February/March 2009, nearly 4 000 led to death, and this represented an overall fatality rate of 4,7 per cent – nearly five times what the WHO regarded as "acceptable" – which was indicative of a very "terrible toll".⁴¹ By that time, roughly 365 Cholera Treatment Centres (CTC) and units had been put into

36 P Thornycroft, "Hundreds of people are dying of cholera in Zimbabwe amid an epidemic that President Mugabe is trying to cover up", *Zimtownship Online Newspaper*, 19 November 2008 (Internet accessed 6 January 2009.)

37 *Ibid.* The severity of the symptoms depends on the dose or the number of bacteria ingested. For detail on this see KJ Ryan and CG Ray (eds), *Sherris Medical Microbiology* (McGraw Hill), pp. 376–377; I Basson, "Is cholera hiding in your water?", *Ibismail* 37, 2006 (Internet accessed 14 January 2009); WHO Media Centre, Fact Sheet 107, 2008 (Internet accessed 24 April 2009) and interview D Munodawafa of WHO Regional Office for South East-Asia, at Maware, Zimbabwe, 19 April 2009.

38 WHO, "Zimbabwe's cholera crisis worsens as number of dead, infected climbs – UN", UN News Centre, 20 February 2009 (Internet accessed 5 March 2009.)

39 IRIN, "30 strains of cholera".

40 IRIN, "30 strains of cholera". Various strains exist, but *Vibrio cholerae* O1 classical strains are facultative intracellular bacteria, which survive and multiply symbiotically inside the aquatic free-living amoebae. These are the most common and most life-threatening strains. For details see H Abd, A Weintraub and G Sandström, *European Society of Clinical Microbiology and Infectious Diseases (ESCMID)*, 15th European Congress of Clinical Microbiology and Infectious Diseases, (Copenhagen, 2005-04-2/5) (Internet accessed 24 May 2009.)

41 Mcgreal and Gilchrist, "Mugabe splashes out".

operation across the country. However, about half of all cholera deaths occurred within the community, rather than in the health facilities.⁴² It was estimated that the number of people dying at home, with no access to healthcare and little money for basic rehydration products such as salt and sugar, reached 60 per cent by the beginning of March 2009 and more deaths were recorded in what the MSF called a huge medical emergency reaching unmanageable levels due to crumbling infrastructure in Zimbabwe.⁴³ An ICDDR report published in March 2009 revealed that given a massive skills flight (brain drain) there was an “inadequate” number of skilled health care personnel, such as physicians, nurses and paramedics, “in most of the health facilities”, and in “one CTC, in the absence of [Oral Rehydration Salts] ORS, [intravenous] IV fluid was administered orally”.⁴⁴ The visiting physicians from the ICDDR, however, commended the “positive attitude” of the health care personnel, “considering the paucity of human resources, limited training in diarrhoea management, and insufficient preparedness”.⁴⁵

Clearly, with the country’s infrastructure neglected by the government for many years, large parts of Harare relied on standpipes and wells for water.⁴⁶ Not all of them provided clean water. It increased the risk of infection. Judging by the statistics provided by the WHO, Zimbabwe’s cholera epidemic escalated until April 2009. More than an estimated 35 000 people were believed to be infected and the recorded cholera death toll topped 1 700 as new cases reached 1 080 by early January 2009.⁴⁷ These were apparently conservative estimates. It is likely that more Zimbabweans perished from cholera in the period from August 2008 to January 2009. The number of people infected by the deadly disease was believed to be significantly higher due to rampant unhygienic levels in the capital and the surrounding areas. Some cases also went unreported. The government was accused of deliberately underestimating the figures and thus grossly minimising the real impact of the disease.

2.3 Aging pipes: urban population growth takes its toll

It was not easy for Zimbabwe, which was experiencing a period of biting economic recession compounded by sanctions to redress the situation. Added to this, according to Lucy Nyandoro in Chitungwiza’s Unit “O” residential area existing sewers were overwhelmed by population pressure and with rapid urbanisation after 1980 the local

42 *Ibid.*

43 Sapa-dpa, “Zimbabwe cholera cases could double”.

44 IRIN, “30 strains of cholera”.

45 *Ibid.*

46 Thornycroft, “Hundreds of people are dying”.

47 J Lynn, “Zimbabwe cholera death toll tops 1 700: WHO”, *Zimtownship Online Newspaper*, 9 January 2009 (Internet accessed 9 January 2009.) See also WHO cited in eTV News, 06:00 Bulletin, 7 January 2009.

town council was unable to cope with the demand for expansion.⁴⁸ Frequent water shortages and interruptions of supply were also witnessed. The town's residents resorted to digging wells for domestic use, thereby exposing themselves to the disease, especially when the sewage pipes imploded leading to groundwater contamination.

When the aging pipes succumbed to pressure, the water was mixed with the raw sewage or effluents underground, hence the cholera outbreak.⁴⁹ The same was true for Budiriro. In fact, most urban centres in Zimbabwe appeared to be riddled with the problem of population growth with no corresponding expansion in sewer or water reticulation systems. Hence, since the late 1990s raw sewage was a common sight in many high density areas of both Harare and Chitungwiza. This was part of daily life in the affected areas. Some houses became islands surrounded by raw sewage, and under these circumstances life went on as if everything [was] normal.⁵⁰ Children literally played in the sewage water pools which characterised many high density suburbs of the capital city and the nearby sprawling town of Chitungwiza. Thus, the outbreak was largely attributed to the mismanagement of water purification infrastructure under conditions of incessant population growth and rising inflation, not only in Harare but throughout the country. Due to extraordinarily high inflation levels (hovering above 150 000 per cent in January 2008 and estimated at 231 million per cent in the same month – the highest in the world,⁵¹ and a near-total breakdown of the governance infrastructure, the state, through its major water supply utility (ZINWA), could no longer afford to import essential water treatment chemicals. Since its effective takeover of the urban water supplies in 2005, the new parastatal had done nothing to improve the lot of the people and was held responsible for the shocking state of affairs that existed and for the deaths of many people.⁵²

The medical infrastructure too, was severely crippled by hyperinflation.⁵³ The sight of cholera patients being rushed in wheelbarrows and other rudimentary forms of transport to the few health centres in Harare and Chitungwiza, was not only heart-rending, but it was also confirmation of the poor state of the economy.

48 Interview with L Nyandoro, social work officer, Harare, 10 January 2009.

49 *Ibid.*

50 *Ibid.*

51 In January 2008, the International Monetary Fund (IMF) pegged Zimbabwe's inflation rate at more than 150 000 percent as the economy continued to crumble. See E Chiwara, "IMF pegs Zimbabwe's inflation at 150 000 percent". *The Zimbabwe Guardian*, 18 January 2008 (Internet accessed 20 January 2009); C McGreal, "Zimbabwe's inflation rate surges to 231 000 000%", *Guardian.co.uk*, 9 October 2008 (Internet accessed 20 January 2009.)

52 Anon., "Zinwa is a disgrace". *Zimbabwe Independent*, 2 October 2008 (Internet accessed 4 May 2009.)

53 See SH Hanke, "Hyperinflation: Mugabe versus Milosevic", *Globe Asia*, August 2008 (Internet accessed 20 January 2009.)

People were dying and many more were “hospitalised”⁵⁴ following the outbreak of cholera in the crowded high density suburbs of Harare and Chitungwiza. The outbreak which started in August increased at the beginning of September 2008, after weeks that saw an increasing number of chronic diarrhoea reports, as a result of a failing clean water system and numerous sewage spills that contaminated the city’s water reservoirs.⁵⁵ The waterborne disease claimed many lives in the country since its outbreak, as Zimbabwe’s water and waste infrastructure had deteriorated.⁵⁶ At the same time, a tottering health system meant the once treatable disease became endemic, as hospitals did not have the supplies to treat victims, while patients could not afford treatment down-payments or private care.⁵⁷ Meanwhile, the Combined Harare Residents Association (CHRA) coordinator for Dzivarasekwa Ward 40, echoed the general plight of residents.⁵⁸ Voices from concerned Harare residents revealed “the insidious fear of a disease” that threatened to “snatch anyone at any time”.⁵⁹ The closure of several local state run hospitals, including major referral centres like Parirenyatwa and Harare hospitals, and the non-availability of medicines and personnel exacerbated the spread of the disease.⁶⁰ The former Health Minister, David Parirenyatwa, conceded that “the epidemic could get worse as the rainy season develop[ed]”.⁶¹ The blame can be laid squarely on the government which was compelled by the situation to seek urgent international assistance to enable it to deal with this emergency.⁶² Especially with so many people dying of cholera it was clear that the disease had exceeded the state’s capacity to handle it without further significant injection of support from the donor fraternity. This made external humanitarian assistance absolutely necessary.

2.4 International donor aid as cholera reaches epidemic levels

When the government declared the cholera outbreak “a national emergency” (not a disaster) this was done as a capitulation gesture to open the door to help from donor

54 People were “admitted” and “hospitalised” in virtually make-shift hospitals, clinics or care centres which were often rushly erected.

55 Anon., “Zimbabwe, Harare: Residents slam ZINWA after fatal cholera outbreak”, wash blog, 8 September 2008 (Internet accessed 9 January 2009.)

56 A Bell, “Zimbabwe: Cholera death rate continues to rise”, 31 October 2008 (Internet accessed 19 January 2009.)

57 *Ibid.*

58 *Ibid.*

59 Mcgreal and Gilchrist, “Mugabe splashes out”.

60 International Federation of Health and Human Rights Organisations (IFHHRO), “Cholera in a time of health system collapse”, *The Zimbabwe Situation News Website*, 3 March 2009 (Internet accessed 13 March 2009.)

61 D Parirenyatwa (Health Minister) cited by Lynn, “Zimbabwe cholera death toll.”

62 Lynn, “Zimbabwe cholera death toll”.

agencies and the international community.⁶³ Clearly, the tragic cholera outbreak in Zimbabwe galvanised international support for the ravaged and vulnerable Southern African nation. For nearly a decade, the country was growing increasingly desperate, but international response to the crisis was dilatory and wholly ineffective. In December 2008, however, UN Secretary-General, Ban Ki-Moon, addressed the UN Security Council regarding Zimbabwe, amid strong US and British pronouncements that they were averse to any power-sharing arrangement that left Robert Mugabe as President. Ban Ki-Moon viewed Zimbabwe's cholera epidemic as the most visible manifestation of a wider crisis. Despite British objections to a Mugabe presidency under the new political dispensation, British Prime Minister, Gordon Brown, acknowledged that Zimbabwe was facing a "humanitarian emergency of colossal proportions", adding that Zimbabwe needed help urgently.⁶⁴ Not allowing their disagreement with Mugabe to obscure their judgement, the British openly declared that they were increasing their humanitarian aid and implored other international players to emulate them. As already noted the IFRC responded positively by donating more than US\$9 million towards meeting the huge challenge facing Zimbabwe. Thus, the cholera epidemic, more than anything else, "provide[d] the international community with the imperative to act and protect the citizens of Zimbabwe".⁶⁵

Indeed, the spread of cholera revealed the state's failure to fulfil the most basic precept of government, notably the responsibility to protect its citizens. In the light of this, the UN General Assembly and the Security Council endorsed the responsibility-to-protect doctrine, declaring that if a state lacked the capacity or will to protect its people from mass atrocities then it was the responsibility of the international community to do so.⁶⁶ It is in this context that the international community – led by the UN with strong South African and US support – was repeatedly called upon to step into the widening "leadership vacuum in Zimbabwe".

The last months of 2008 were particularly dire. The political situation was steadily declining since the power-sharing agreement had been signed in September. Hyperinflation and the country's lack of creditworthiness combined to lead to the collapse of not only the economy, but the entire social sector.⁶⁷ Health experts warned that the cholera outbreak could put as much as half the country's population at risk.⁶⁸ Thus, Zimbabweans affected and infected with cholera, were in dire need

63 Anon., "Zimbabwean 'Government' must account for anti-cholera resources", *Spectrum News*, 5 December 2008. (Internet accessed 9 January 2009.)

64 Anon., "UN Security Council to discuss Zimbabwe", *The Zimbabwe Times*, 10 December 2008 (Internet accessed 5 May 2009.)

65 A Noyes, "Finally, an urgency to aid Zimbabwe", *Zimtownship Online Newspaper*, 9 January 2009 (Internet accessed 9 January 2009.)

66 *Ibid.*

67 *Ibid.*

68 *Ibid.*

of international assistance. Nevertheless, while there were reports that the UN aid agencies, especially the WHO, OCHA and UNICEF had stepped up efforts to fight cholera in Zimbabwe, CHRA feared that the aid might be usurped by the authorities; and find a way to bankrolling the government's populist projects.⁶⁹ Therefore, while the inflow of support from well-wishers and global multilateral institutions was a positive gesture, Harare residents raised concern on the effectiveness of the government's disbursement mechanisms.

With donors increasingly touched by the plight of ordinary citizens and focused on assisting Zimbabwe, it was however not gratifying to note that allegations of embezzlement of aid money were rife. This did not inspire confidence at all. CHRA was dismayed by the failure of the state and its parastatals to account for the funds which had been designated for the control of cholera and provision of clean water to the residents of Harare.⁷⁰ In mid-November 2008, the Reserve Bank of Zimbabwe (RBZ), for instance, allocated large sums of money to the tune of R18 million and vehicles to ZINWA towards the production and supply of water and sewer reticulation in the city, but up to January 2009 nothing substantial in this regard was done on the ground.⁷¹ In some parts of the city residents were seen queuing for water from UNICEF trucks which had been deployed to salvage the situation. Lamentably, by mid-October 2009 the cholera infested areas like Chitungwiza were still without water. Under these circumstances, to prevent another serious resurgence of the pandemic more international aid had to be pledged and given to recipients under stricter conditions to prevent any likelihood of misappropriation. Thus ZINWA's failure to deliver on its moral responsibility meant continued criticism of the parastatal body by urban residents in particular.

2.5 CHRA: Residents voice their dissatisfaction against ZINWA

Zimbabwe National Water Authority (ZINWA) was facing insurmountable challenges as residents increasingly questioned its role and efficacy. Simbarashe Moyo of the Combined Harare Residents Association (CHRA) told *Newsreel* in early September 2008 that the water situation was desperate and more people would die if it was not addressed. He questioned why the Authority was "continuing to run the city when they [were] failing". From the beginning the association tried to convince the Deputy Minister of Water Affairs and in particular the Harare City Council to take over water and waste management. Moyo added that the city's

69 Anon., "Zimbabwean 'Government' must account for anti-cholera resources".

70 *Ibid.*

71 *Ibid.*

residents held the government responsible for the water crisis and also held it accountable for the deaths as a result of the city's dirty water.⁷²

The CHRA, for many weeks, lashed out at ZINWA for failing to supply clean water to the city's residents. It made numerous calls for the city's water and sanitation services to be handed back to the council – to no avail.⁷³ To a large extent the events leading to the placing of the water portfolio under ZINWA were reflective of the politics of patronage. ZINWA was launched and firmly put under government control, especially after ZANU-PF had lost municipal/mayoral elections to the MDC in 2000. The directorship of the water authority after the controversial parliamentary and municipal poll had been bestowed on the former Chegutu mayor, Willie Muringani, who had lost that election. With pressure on government to deliver clean water to the people in the wake of the cholera epidemic, the government subsequently returned the urban water supply portfolio to the municipality of Harare controlled by an MDC mayor. This came about when the then acting Finance Minister, Patrick Chinamasa, dissolved the discredited ZINWA with effect from January 2009, and handed over its responsibilities to local authorities. This was one of a number of radical measures meant to revive Zimbabwe's faltering economy. In his words, "ZINWA has been unable to discharge its mandate, despite government efforts to bail the utility out due to bureaucratic inefficiencies".⁷⁴ Eventually, the government was forced to succumb to the demands of the residents.

The residents' association explained in a statement released at the end of October 2008 that the people living in Budiro and other residential areas like Mabvuku, Glen View, Dzivarasekwa, Tafara, Ruwa, and Masasa Park had resorted to fetching water from shallow and unprotected wells as a result of the persistent water shortages. In addition, sewer bursts were rife and were not attended to by ZINWA. Hence, "the shortage of water coupled with the polluted environment in which raw sewage flows through homes and along paths and roads, has resulted in cholera and other related disease outbreaks".⁷⁵

The 2008-2009 cholera outbreak in Harare therefore prompted the residents' association to constantly denounce the water authority⁷⁶ and it seemed as if a lasting solution could be provided by heeding calls by the CHRA for ZINWA to hand over control of water supply and sewer reticulation management to the Harare city

72 A Bell, "Zimbabwe: Harare residents slam ZINWA after fatal cholera outbreak", 4 September 2008 (Internet accessed 9 January 2009.)

73 *Ibid.*

74 P Chinamasa, cited by a correspondent, "Chinamasa dissolves ZINWA", *The Zimbabwe Times*, 30 January 2009 (Internet accessed 4 May 2009.)

75 Bell, "Zimbabwe: Cholera death rate continues to rise".

76 Bell, "Zimbabwe: Harare residents slam ZINWA".

council.⁷⁷ In addition, the residents also vociferously called for privatisation of the water sector. However, Johann Tempelhoff, writing on the commoditisation of water provision, cites several merits and demerits of privatisation. In the main, he argues that privatisation would restore efficiency to water management, particularly after the adoption by many Southern African countries of the “user pays” principle.⁷⁸ Lamentably though, the poor might not be in a position to pay for the water and private suppliers might not be willing to supply water to people who can ill-afford to pay for it. Besides some clamouring for private control over water in Zimbabwe, others called for water rationing.

C Tanyaradzwa, a high density suburban resident of Kambuzuma, *inter alia* said: “I do not know what the water situation in the rest of the country is like, but if it is even as bad as what we are seeing in Harare then there is no way we are going to completely deal with cholera.”⁷⁹ What was particularly shocking was that the relevant authorities were absolutely quiet, as if everything was running smoothly. Indeed, as Tanyaradzwa argued, “there are parts of Harare that have forgotten what tapped water looks like ... [as there are] parts that only know tapped water as dirty liquid that threatens to poison their families”.⁸⁰ The cholera crisis, in fact, revealed that there were some parts of the city that had very good supplies of water whilst others were getting a raw deal. The affluent suburbs were generally better supplied than the poorer ones. This suggests that cholera was both a racial and a poverty issue. Under these circumstances, Tanyaradzwa asked: “Why do the authorities not ‘sensibly ration’ the little that is there so that everyone gets something?” This was certainly a healthier and more hygienic alternative than “leaving some people with no water all the time while others always have it”.⁸¹ Clearly, efforts to deal with the cholera pandemic would come to nothing if there was no pure water.

The usefulness of ZINWA as a water provisioning and treatment body remained severely under attack. The legitimacy or otherwise of this water entity can be measured by the numerous complaints the residents of Harare voiced against it. Whether the residents’ call for the replacement of ZINWA by the city council was a long-term solution to the problem or not, remained to be seen, but what could not be denied was that the water authority failed to deliver on its mandate to the people.

77 Anon., “Zimbabwe, Harare: Residents slam ZINWA after fatal cholera outbreak”, wash blog, 8 September 2008 (Internet accessed 9 January 2009.)

78 JWN Tempelhoff, “The commodification of water in the arid and semi-arid parts of South Africa: A preliminary historical exploration”, *Historia* 50(1), 2005:123-146; Makurira and Mugumo, “Water sector reforms in Zimbabwe”, chapter 14.

79 C Tanyaradzwa, Letter to the editor, “Let’s have equitable rationing of water: What exactly is happening with water in Harare?” *The Herald*, Opinion and Analysis, 31 March 2009 (Internet accessed 31 March 2009.)

80 *Ibid.*

81 *Ibid.*

Hence, if ZINWA or the government was to blame for the water woes culminating in the outbreak of cholera, then the witch-hunt of the four months August to December 2008 was ill-informed and should immediately be ceased.

2.6 Witch-hunt: Biological warfare or negligence?

In circumstances of poverty, impending mass starvations, disease and cholera deaths, it was imperative that the government showed empathy with the suffering population. This was not the time to feed people on conspiracy theories. Rather, it was a time to act in a manner that would help address the problem. The first step in that direction would have been a mere acknowledgement by the government that people were forced to drink contaminated or unsafe water resulting in cholera. Officials of ZINWA testified to this by admitting that “the situation [was] constrained by costs, poor funding and frequent power cuts”, which meant that “water [could not] be properly purified, if at all”.⁸² A witch-hunting campaign to find out who had contaminated the water in the first place, given clear scientific causation factors about the disease, was a futile exercise. The allegation on state-controlled national television by the former Minister of Information, Sikhanyiso Ndhlovu, that “the cholera epidemic in Zimbabwe [was] a serious biological, chemical warfare, a genocidal onslaught, on the people of Zimbabwe by the British”,⁸³ was not a logical argument because cholera epidemics plundered the country not only during this most recent outbreak (2008–2009), but also sporadically in the past and since the turn of the new millennium – due to deteriorating water and sewage systems.⁸⁴ The country’s decade-long political and economic crisis thus witnessed the almost total disintegration of infrastructure in the once thriving Zimbabwean cities, thereby leading to cholera occurrences.⁸⁵

Indeed, outbreaks of cholera were not a novel phenomenon in Zimbabwe. For instance, there is sufficient evidence that the disease occurred in the country in the 1970s, 1980s, 1990s and early 2000s, but it was effectively contained because the health delivery system in Zimbabwe, with its good laws and a sound health act, was in a position to deal effectively with such pandemics. Furthermore, there is

82 Bell, “Zimbabwe: Harare residents slam ZINWA”.

83 P Mutuzu, “Zimbabwe’s grief, cholera and strange things”, *Zimdaily News*, 19 December 2008 (Internet accessed 19 January 2009.) See also P Mutuzu, “Zimbabwe - Harare - witches: ‘double, double toil and trouble; fire burn and cauldron bubble’”, *Zimdaily News*, 19 December 2008 (Internet accessed 19 January 2009.)

84 Indeed, as Zimbabwe’s Minister of Health and Child Welfare, Henry Madzorera, noted on 30 March 2009: “A lasting solution to a devastating cholera epidemic that has left more than 4 000 people dead in the country lies in local authorities providing clean water to households.” See H Madzorera, cited in S Chirinda, “Clean water provides lasting solution to cholera”, *ZimOnline Zimbabwe’s Independent News Agency*, 31 March 2009 (Internet accessed 2 April 2009.)

85 Bell, “Zimbabwe: Harare residents slam ZINWA”.

clear evidence that the British or any other external forces were not responsible for Zimbabwe's cholera outbreaks. On 20 February 2006, for example, the WHO Zimbabwe released a report stating that a cholera outbreak had been recorded in Chikomba (Chivu) on 28 November 2005.⁸⁶ Exactly a month later, a Harare outbreak was reported in the Glen View high density area.⁸⁷ Thereafter, many other parts of Zimbabwe began to experience the same problem. These outbreaks, according to Harare residents, were caused by "contaminated water as government financially struggled to chlorinate its water supplies".⁸⁸

In January 2007, the state-run ZINWA issued a stark warning through the Associated Press: "A breakdown at a major sewage treatment plant had left it spewing 72 mega-litres of raw sewage per day into a river that feeds into Lake Chivero, Harare's main source of drinking water."⁸⁹ On 2 February 2007, Zimbabwe state radio also reported:

"Nineteen people have contracted cholera in the Zimbabwean capital, Harare, in the first outbreak of the often-deadly disease in the city in a year. The 19 are from the impoverished eastern townships of Mabvuku and Tafara, where residents have gone without clean running water for days and have been using unprotected wells."⁹⁰

In many suburbs as indicated in the press, "garbage [went] uncollected for weeks because the authorities [had] no fuel to power waste collection, while sewage [flowed] freely from broken pipes. Authorities [said] they [had] no money to fix it."⁹¹ The same press further reported that health officials were dispatched to the area "to hand out water purification tablets" in order to bring the situation "under control".⁹² These admissions do not seem to imply that the British or any external party were responsible for the cholera outbreak. In fact, the conditions leading to the disease did not seem to have changed to justify British involvement, except that the economic and political situation deteriorated further since the crisis had begun in the late 1990s, save for a few months of the existence of the GNU. The inclusive government was able to attract some support for cholera activities. The problems related to water supply, therefore, were a perennial feature in Zimbabwe contrary to recent speculation that the spread of the disease was engineered by the West.

Neglect of the people was the best way to explain the situation facing the country in the past and present. In other parts of the world, negligence and dereliction of duty like this, that caused a death toll of over 1 000 between August

86 *Ibid.*

87 *Ibid.*

88 *Ibid.*

89 *Ibid.*

90 Mutuzu, "Zimbabwe's grief". See also Mutuzu, "Zimbabwe – Harare – witches".

91 *Ibid.*

92 *Ibid.* See also "Zimbabwe: Complex Emergency Situation Report, 2 FY 2009", (Internet accessed 15 January 2009.)

2008 and January 2009 and over 4 000 by April 2009 (and deaths continued to mount), would have been met with great public outrage, lawsuits, multiple resignations, imprisonments and impeachments.⁹³ Such action would be justified because most of the government's earlier arguments regarding the outbreak of cholera in Zimbabwe were not only baseless and unsubstantiated by facts on the ground, but were tantamount to irrational witch-hunt machinations. In the main, therefore, Zimbabwe desperately needed transparent, accountable, honest, responsible and sensitive leadership,⁹⁴ as the Zimbabwean disaster was not a natural one but one of cold, arrogant and irresponsible governance.⁹⁵ Furthermore, this level of contempt for the people's right to clean water unfortunately compromised the health of citizens in adjacent countries, particularly South Africa⁹⁶ and to some extent neighbouring territories such as Namibia, Mozambique, Botswana, Zambia and Malawi as the cholera pandemic rapidly sprawled beyond Zimbabwe's borders. Clearly, it has assumed a regional dimension.⁹⁷

3. CONCLUSION

By way of conclusion, Zimbabwe's cholera outbreak was just one sign of the disintegration of a once-admired healthcare structure that had virtually ceased to function since the last quarter of 2008 due to blatant neglect, a serious brain drain and a crippling lack of funds.⁹⁸ Cholera is both preventable and curable. However, a collapsing socio-economic and political system was not ideal for the containment of a disease that by December had assumed epidemic proportions. Turning around Zimbabwe's economic fortunes was clearly no mean task. A great deal of investment would have to go into water purification, refuse collection, medical infrastructure and other social amenities that facilitated a clean environment in the country's urban centres as a major safeguard against cholera. More needed to be done to overturn a battered governance record for the past ten years. On a long-term basis, Zimbabwe needed a sustainable water and sewer management framework to avoid similar cholera disasters in future. Attention also needed to be paid to the rural water infrastructure if cholera was to be stamped out throughout the country.

93 *Ibid.*

94 Anon., "Zimbabwean 'Government' must account for anti-cholera resources".

95 *Ibid.* See also Anon., "Zimbabwe: UN issues warning over cholera", *Water and Sanitation Africa* 3(3), November/ December 2008:23.

96 Details on cholera in South Africa and the extent of this pandemic across the Limpopo can be gleaned from Tempelhoff, "Leaving behind a 'twisted soul'", *Journal for Contemporary History*.

97 A discussion of cholera outbreaks throughout the Southern African region is beyond the scope of this article.

98 It was estimated that Harare alone needed 63 million euros to rectify its water problems. See Municipal reporter, "Harare needs 63 million euros for water", *The Herald*, 10 April 2009 (Internet accessed 14 April 2009.)

Cholera outbreaks in Zimbabwe were continuing unabated and the current discourse around the 2008-2009 outbreaks would only end when the pandemic was finally brought under control. Two months before the end of 2009 there was no end in sight, largely due to the fact that the nascent inclusive government was still crippled from the point of view of harnessing adequate financial and medicinal resources to effectively combat this plague. Cholera cases, whether linked to the Zimbabwean outbreaks or not, had far-reaching and deleterious consequences on other neighbouring states.

However, the committed response to the crisis by the unity government and the donor community brought some amelioration to parts of Zimbabwe, for example, Chinhoyi, Harare and in particular Budiriro and Chitungwiza, although the epidemic had not been completely brought under control by October 2009. Medical experts maintained that after February (the month the disease reached its peak) Zimbabwe's cholera epidemic tapered off, but the disease remained a threat. The risk was ever-present. It was an ongoing epidemic until such time as the dilapidated nature of the water, sewer and sanitation infrastructure will have been fully rehabilitated. The omnipresent nature of cholera in Zimbabwe can be underlined by the fact that in October 2009 a senior government official admitted the death of five people and the infection of 30 more people in the most recently recorded outbreak in the Mashonaland and Midlands provinces.⁹⁹ In fact, new cases continued to be reported throughout the country as the potential for another outbreak continued to exist. The threat of cholera was thus ubiquitous, partly because of government denialism between August and November 2008 and partly as a consequence of the existence of a collapsed water and sewer infrastructure that could not be remedied immediately due to the unavailability of funds. Nevertheless, a fresh major outbreak of the water-borne disease could be handled better than the previous one due to UNICEF's continued presence, although some major partners seem to have retracted. A recurrence of another epidemic of the 2008/2009 proportions can only happen given the imminent signs of disintegration of the GNU.

99 Herald reporter, "Cholera claims five people", *The Herald*, Harare: 20 October 2009, p. 2. For details on some recorded outbreaks in the month of May to illustrate that the cholera scare has not completely vanished see O Chikari, *The Zimbabwe Times*, "School close as cholera kills 10", 13 May 2009 (Internet accessed 25 May 2009.)



CHOLERA OUTBREAK IN ZIMBABWE

